ATTACHMENTS
CCO SERVICES

Page No.

MAPB-087-005-0
Date: 9/1/87

Community Care Services

FORM APPROVED
OMB NO 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [M] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.

2 PATIENT'S DATE OF BIRTH: MM | DD | YY

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE):
609 Willow
Anytown WI 53725
TELEPHONE NO

5 PATIENT'S SEX: MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): 1234567890

7 PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - D

10 WAS CONDITION RELATED TO:
A PATIENT'S EMPLOYMENT: YES [ ] [X] NO
B ACCIDENT: AUTO [ ] [ ] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): M - 8
TELEPHONE NO.

11a CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
SIGNED / DATE / / / / / / / /

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ◄ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES / / / / / / / / / / /

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK / / / / / / /

18 DATES OF TOTAL DISABILITY FROM / / / / / / / / / / THROUGH / / / / / / / / / /

DATES OF PARTIAL DISABILITY FROM / / / / / / / / / THROUGH / / / / / / /

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED — DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] [ ] NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1 V68.9 Unspecified Encounter for Administrative Purposes
2
3
4

B EPSDT YES [ ] [ ] NO
FAMILY PLANNING YES [ ] [ ] NO
PRIOR AUTHORIZATION NO

24

A DATE OF SERVICE FROM / TO	B * PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * TOS	H LEAVE BLANK
02/01-29/88	0	W6300	CCO Administrative Fee		XX XX	29	9	
								Patient Spenddown $

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
DATE MM/DD/YY I.M. PROVIDER

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) / / / YES [ ] / [ ] NO / /

27 TOTAL CHARGE: XX XX

28 AMOUNT PAID: XX XX

29 BALANCE DUE: XX.XX

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO
I.M. Billing
1 W Williams
Anytown WI 53725
I.D. NO. 87654321

32 YOUR PATIENT'S ACCOUNT NO: 1234JED

33 YOUR EMPLOYER I.D. NO / / / / / / / / / / /

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

790 00

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR COMMUNITY CARE ORGANIZATIONS

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To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the Patient and Insured (subscriber) Information section.

Program Block/Claim Sort Indicator
Enter the appropriate **CLAIM SORT INDICATOR** for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

'D' - Corrective Shoes
- Durable Medical Equipment (unless dispensed by a therapist)
- Hearing Aids

'M' - Independent Nurse
- Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Nurse Midwife
- Rehabilitation Agency
- Community Care Organization

'P' - Chiropractor
- Family Planning

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NATIONAL HCFA 1500 CLAIM FORM
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'P' - Free Standing Ambulatory Surgery Center
- Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Physician
- Rural Health Agency

'T' - Therapy - Occupational, Physical, Speech and Hearing
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME
Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME
If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank. When billing for a newborn, enter the mother's last name, first name, middle initial and date of birth in MM/DD/YY format.

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ELEMENT 4 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

ELEMENT 5 - PATIENT'S SEX
Specify if male or female with an 'X'.

ELEMENT 6 - INSURED'S ID NUMBER
Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage

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OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO
If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS
This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

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ELEMENTS 12 - 13
(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY
Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN (not required)

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY (not required)

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS
Diagnosis code V68.9 - Unspecified Encounter for Administrative Purposes must be entered.

ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER
(not required)

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ELEMENT 24 - SERVICES

Element 24A - Date of Service

Enter the FROM and TO dates of service in MMDDYY format in column A.

Element 24B - Place of Service

Enter the appropriate place of service code in column B for each service. Refer to Attachment 4 of this bulletin for a list of allowable place of service codes for Community Care Organizations.

Element 24C - Procedure Code and Description

Enter the appropriate procedure code and matching description for each service performed. Refer to Attachment 3 of the bulletin for a list of allowable procedure codes/descriptions for Community Care Organizations.

Element 24D - Diagnosis Code Reference (not required)

Element 24E - Charges

Enter the total charge for that month.

Element 24F - Days or Units

Enter the total number of days being billed per month.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment 4 of this bulletin for a list of allowable type of service codes for Community Care Organizations.

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Element 24H - Recipient Spenddown

Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE

The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

ELEMENT 26 -

(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 27 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

ELEMENT 29 - BALANCE DUE

Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

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ELEMENT 31 - PROVIDER NAME AND ID NUMBER

Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number.

ELEMENT 32 - PATIENT ACCOUNT NUMBER

Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)

ATTACHMENT 3

COMMUNITY CARE ORGANIZATION SERVICES

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HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE FOR COMMUNITY CARE ORGANIZATION (CCO) SERVICES

The new HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

Prior to 01/01/88	Effective 01/01/88	Mod	New Description	Copayment
05000	W6300	n/a	CCO Administrative Fee	n/a

ATTACHMENT 4

COMMUNITY CARE ORGANIZATION SERVICES

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PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	ø	Other

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	9	Other - CCO Services